COOK COUNTY HEALTH

Cook County Health Provider Compliance Program

Annual Report
Fiscal Year 2018
December 1, 2017 – November 30, 2018

February 28, 2019

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I. Introduction

Cook County Health (CCH) Corporate Compliance incorporates two (2) distinct Compliance Programs: CCH as a provider of health care services and the CountyCare Medicaid Health Plan. Provider services occur within both CCH hospitals (John H. Stroger, Jr. Hospital of Cook County and Provident Hospital of Cook County), multiple outpatient clinics, correctional medicine at the Cook County Jail and Juvenile Temporary Detention Center, and the Cook County Department of Public Health. It also includes physicians and others that provide direct care to patients, and workforce members not directly involved in patient care. Although the CountyCare Medicaid Health Plan's Compliance Program is addressed through a separate annual report, both programs function at the system level and are committed to the mission of Cook County Heath:

> *"To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies which promote and protect the physical, mental and social well-being of the people of Cook County."*

Corporate Compliance supports CCH's Mission through a departmental Mission updated and approved by the Audit and Compliance Committee of the Board of Directors on September 20, 2018. The mission reads,

> *"The Corporate Compliance Program upholds the mission, vision, and core values of Cook County Health by:*
> - *Developing standards to guide everyone affiliated with CCH to "Do the Right Thing"*
> - *Increasing compliance awareness through education and training*
> - *Promoting collaboration, honest behavior, mutual respect, and professional responsibility*
>
> *to support compliance with applicable laws, regulations, and system-wide policies."*

Corporate Compliance similarly updated the Compliance Vision statement:

> *"To ensure safeguards are in place for our patients, health plan members, health plan providers, the residents of the county of Cook, and our workforce members, staff, and the public at large, the Corporate Compliance Program will be a resource to everyone affiliated with and cared for by Cook County Health."*
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> *(For the purposes of this statement, "affiliated" is defined as all patients, health plan members, health plan providers, the residents of the county of Cook, and workforce members that include employees, medical staff, house staff, Board members, volunteers, students, partners, consultants, agency personnel, and vendors.)*

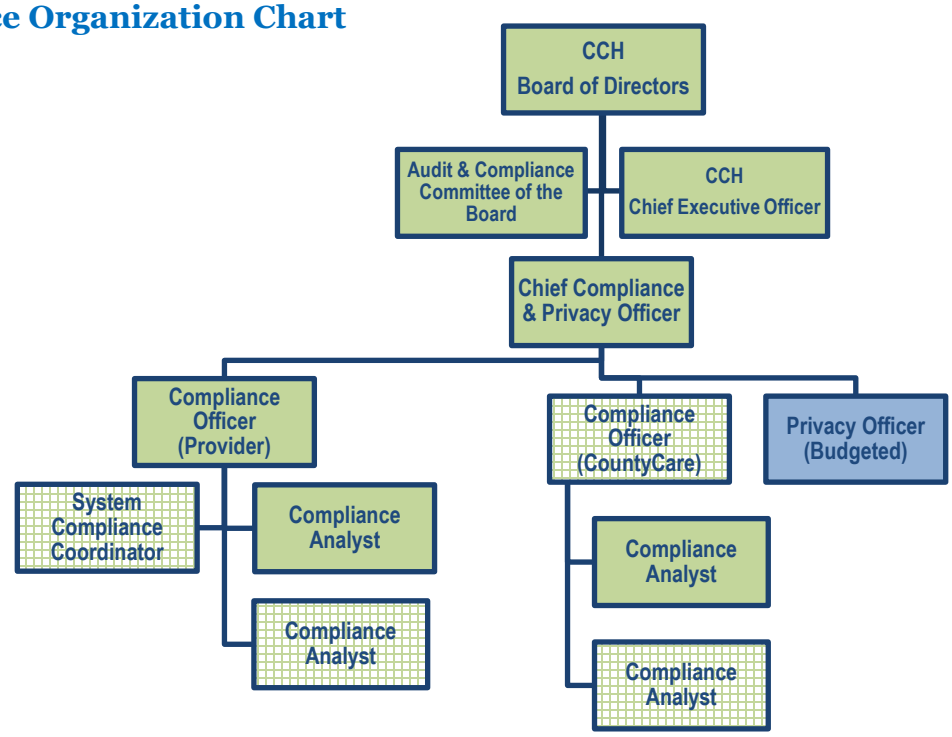
This Annual Report presents the activities throughout County fiscal year 2018 of the CCH Provider Corporate Compliance Program under the executive leadership of Cathy Bodnar, Chief Compliance and Privacy Officer, and the operational leadership of Dianne Willard, Compliance Officer. This report also serves to demonstrate the effectiveness of the compliance program by

looking at infrastructure, communication strategy and channels. In addition, this report provides an assessment of the CCH Provider Compliance Program by using the seven (7) Compliance Program Elements of a comprehensive compliance program delineated by the Office of Inspector General (OIG).

II. Building Blocks – Program Infrastructure and Scope

The Annual Report begins with a look at the activities of the Program that incorporate efforts to foster an infrastructure that produces a comprehensive compliance program. The existing Departmental Organization Chart follows:

Compliance Organization Chart



The lightly shaded positions indicate the new hires within FY18. Four (4) of the 7-positions within Corporate Compliance were filled within the fiscal year, including the Compliance Officer assigned to CountyCare. Although this placed a significant strain on the existing resources, the performance by the existing team members was noteworthy. Management of the core elements of the Program continued while an individualized development plan for each new team member was undertaken. This was critical to the success of each individual and the Program overall.

Corporate Compliance Program Scope

Cook County Health activities that fall into the Corporate Compliance purview are:

- Interpretation of laws, rules, and regulations and organizational policy as they relate to Corporate Compliance;

- Accurate Books and Records;
- Anti-kickback Activities;
- Conflict of Interest;
- Emergency Medical Treatment and Labor Act (EMTALA);
- False Claims;
- Financial Integrity;
- Fraud, Waste, and Abuse;
- Integrity in both Marketing and Purchasing Practices;
- Patient Privacy, Confidentiality, and Security (HIPAA);
- Research, Clinical Trials, and Grant Compliance; and
- Undue Political Activity/ Operational Influence.

III. Being Present – Communication – Fostering Transparency

A. Communication Strategy

The ongoing organizational compliance communication strategy has been to increase the CCH workforce awareness of the following topics:

- Code of Ethics;
- Privacy, Confidentiality, and Security;
- Accessibility of the Compliance Officer and the compliance team;
- Availability through multiple modalities;
- Responsibility to report potential/actual issues; and
- Non-retaliation.

B. Communication Channels

Within FY18, the Corporate Compliance Program communicated the aforementioned topics utilizing multiple formats:

- E-mail communications;
- Organizational newsletters (System Briefs);
- Record Retention guidance;
- Annual education;
- Screen savers;
- Attendance/presence at team meetings;
- Compliance Program business cards;
- Pens with the compliance hot line number;
- Privacy Protector wrist bands;
- Code of Ethics posters; and
- Dual employment and conflict of interest reporting.

IV. Compliance Program Structure: Performance of the Elements

Element 1

The development and distribution of written Code of Ethics, as well as written policies and procedures that promote the hospital's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, coding and billing risk areas, and financial relationships with physicians and other healthcare professionals.

A. Policies and Procedures & Work Plan Activities

Policies and Procedures

Developed, updated, and performed triennial reviews on multiple system policies related to general compliance, governance, and HIPAA. Functioned as a reviewer for numerous organizational policies with compliance and/or privacy elements. Continue to participate on the CCH Policy Review Committee to ensure uniform system-wide standards are met.

Work Plan Activities

In addition to policy and procedure activity, Corporate Compliance worked with operational areas to assess compliance with procedures and/or regulatory requirements.

- Annual Education

  Responsibility for the ongoing operations and day-to-day management of the CCH electronic learning management system (LMS) for all mandatory annual training for the entire CCH workforce (employees and contractors) was transitioned to Wayne Wright, Director of Organizational Development and Training in Human Resources.

  Corporate Compliance remained subject matter expert for two (2) mandatory annual education modules, Fraud, Waste, and Abuse and Code of Ethics. Both modules were updated in to comply with regulatory and contractual requirements. In addition to maintaining responsibility for other elective modules relating to safeguarding protected health information.

- Record Retention

  As a government entity, all documents must be reviewed to determine if they are considered "public records." Public record is defined in 50 ILCS 205/3 is defined as *"(a)ny book, paper, map, photograph or other official documentary material, regardless of physical form or characteristics, made, produced, executed or received by any agency…or in connection with the transaction of public business and preserved…as evidence of the*

organization, function, policies, decisions, procedures, or other activities thereof, or because of the informational data contained therein.

CCH follows an approved Application for Authority to Dispose of Local Records, known as the Record Retention Schedule. The Schedule dates back to 1985, it contains 1,237 pages with 4,395 different records and retention periods. Over the past year, Corporate Compliance has requested and received permission to destroy each record on the Records Retention Schedule based upon the regulatorily defined retention period.

With the completion of the new Professional Building at 1950 West Polk, Corporate Compliance coordinated significant efforts to educate staff on record retention and appropriate record destruction. Corporate Compliance also worked with Health Information Management to walk through each floor of the Administrative Building and communicate proper identification and retention of documents prior to the Administrative Building being vacated by a majority of its workforce.

Departmental efforts with the aforementioned activity deferred a project to update the current Record Retention Schedule to a leaner, more intuitive document for Cook County Health. This project remains on the Corporate Compliance work plan for FY19.

- <u>Dual Employment and Accounting of Disclosure Surveys</u>
  To support organizational transparency, worked with Business Intelligence to internally develop a survey for all Cook County Health employees that combines two (2) elements, dual employment and conflict of interest.

  Completion of an annual Dual Employment survey is required whether or not a CCH employee participates in external employment. This requirement is promulgated by the Rules of the Board of the Cook County Commissioners, CCH Dual Employment Policy and CCH Personnel Rules.

  Historically, a subgroup of CCH employees, those that influence procurement or function in any decision-making capacity on behalf of CCH, were required to disclose additional information related to external relationships and activities. The purpose of this survey is to assess whether a conflict of interest exists. This survey is a mandatory requirement pursuant to the CCH Conflict of Interest policy. This year, the conflict of interest questions were incorporated with the dual employment questions resulting in one survey for all employees. This survey collects employee disclosures for review by leadership.

The survey requires a two-step review process. Once completed by an employee, the survey is submitted to their operational leader. The operational leader reviews the submission. Once reviewed and approved, the survey is routed for a secondary review by the operational leader's supervisor. At each step of the review, the reviewer has the ability to reject a submission, sending the survey back to the individual for more specificity. Summary information will be compiled and shared with the Corporate Compliance Executive Steering Committee.

- 340B Compliance
  Administered through the Health Resources and Services Administrations (HRSA) Office of Pharmacy Affairs, the 340B Drug Pricing Program has significant program integrity requirements. Corporate Compliance continued to function as a resource for the organization's 340B Drug Pricing Program managed within the Department of Pharmacy that requires drug manufacturers to provide outpatient drugs to eligible health care organizations such as CCH at significantly reduced prices.

Element 2

The designation of a Chief Compliance Officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who reports directly to the CEO and the governing body.

B. Compliance Office and Committees

The graphic below illustrates the communication and reporting structure. Cathy Bodnar, the Chief Compliance & Privacy Officer, reports to the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer. In turn, the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer each report to the CCH Board of Directors.

The primary duties of the **Chief Compliance & Privacy Officer** include the following:

- Serving as an internal consultant and resource for compliance and matters;
- Overseeing and monitoring the ongoing functions of the Corporate Compliance Programs for both the CCH provider side of the system and the CountyCare health plan;
- Participating in regular, CCH-wide risk assessments to understand potential vulnerabilities;
- Acting as the Privacy Officer for CCH to assure compliance with HIPAA regarding protection of patient and member health information;
- Reporting on a regular basis to the CCH governing bodies;
- Periodically revising the Corporate Compliance Program Plan, with input from the Audit & Compliance Committee of the Board of Directors and Executive Management in light of changes directed to the needs of CCH and the laws and policies of federal, state, and county bodies;
- Developing, coordinating and participating in training programs that focus on the elements of the Corporate Compliance Program and providing training such that workforce members are knowledgeable of and comply with the Code of Ethics, compliance policies, laws and regulations;
- Coordinating and overseeing compliance auditing and monitoring activities;
- Responding to reports of issues or suspected violations related to compliance by independently investigating these matters, as appropriate, and working with operational leadership, Human Resources, and General Counsel in the determination of corrective action warranted based on policies;
- Assuring, through consultation with Human Resources and General Counsel, that guidance provided through CCH disciplinary policies are applied fairly, equitably, appropriately, and consistently;
- Developing policies and programs that encourage CCH personnel to report suspected fraud and other improprieties without fear of retaliation or retribution; and
- Reviewing and incorporating updated compliance, privacy, and security language within agreements and contracts to require third party vendors' adherence to applicable regulations and laws.

The **Audit & Compliance Committee of the Board** advises the CCH Board of Directors regarding the implementation of standards and processes to assure professional responsibility and honest behavior, compliance with regulatory requirements, and risk management.

In addition to the aforementioned relationships, the Chief Compliance and Privacy Officer receives support and guidance from the internal **Corporate Compliance Executive Steering Committee**, an assembly of executive leaders within CCH, including but not limited to, the CEO, Deputy CEO, System Director of Internal Audit, Chief Medical Officer, and others.

Element 3

The development and implementation of regular, effective education and training programs for all affected employees.

C. Education and Training

1. *New Employee Orientation*
   Presented an "Introduction to Corporate Compliance and HIPAA", at twenty-seven (27) orientation session speaking to over 1,200 workforce members.

2. *Targeted Education*
   Provided thirty-seven (37) additional education training sessions to 485 attendees. Continued utilizing interactive training sessions which focused on story-telling as a means to communicate information on HIPAA and CCH policies. Focused on current matters brought to Corproate Compliance attention, the impact on patients, and proactively improving compliance to areas such as,
   - Resident program coordinators;
   - Residents in surgical units;
   - Patient Access Department;
   - Outpatient clinics;
   - CORE Center;
   - Physical Therapy/Occupational Therapy;
   - Oak Forest Mail Order Pharmacy; and
   - Correctional Health at Juvenile Temporary Detention Center.

3. *Annual Compliance Education*
   As noted earlier in this report, updated two (2) annual education modules on the Code of Ethics and Fraud Waste and Abuse.

Element 4

The maintenance of a process, such as a hot line, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

D. Effective Lines of Communication – Receiving and Responding to Complaints

1. *Infrastructure Activities*
   a. Assisted our workforce members through:
      - A hot line service by a third party to preserve anonymity if desired. The individual is given a code number related to their report, and can call back or check the website using that code number to review comments and updates.
      - A separate toll-free number for privacy breaches.

- Expanded role in collaborating with Patient Relations to assist in resolving compliance-related issues.

b. Managed two (2) e-mail addresses for Compliance (compliance@cookcountyhhs.org) and Privacy (privacy@cookcountyhhs.org).
c. Established and engaged internal and external resources to assist with investigations and provide governmental and national perspectives on compliance issues.
d. Identified trends and patterns to mitigate organizational risks and facilitate operational improvement.
e. Presented trends and patterns to the Audit and Compliance Committee of the Board.

2. *Process for Responding to Inquiries, Issues and Complaints*

The work flow process follows:

a. Investigate the allegation;
b. Determine the area(s) affected;
c. Collaborate with operational leadership and appropriate departments;
d. Review and follow organizational policy, federal, state, and county regulations related to the incident for mitigation and remediation. These may include further auditing of documentation, mitigating harm and potentially informing the appropriate government entity;
e. Follow HIPAA breach notification rules that require sending a notification and apology letter to the affected individual(s), reporting to the Centers for Medicare and Medicaid (CMS), and, in the case of breaches that affect over 500 individuals, notifying the media;
f. Collaborate with operational area to determine and facilitate a corrective action plan including education as needed;
g. Respond to the complainant; and
h. Respond to governmental entities as required by law. (e.g. CMS, OCR, HFS).

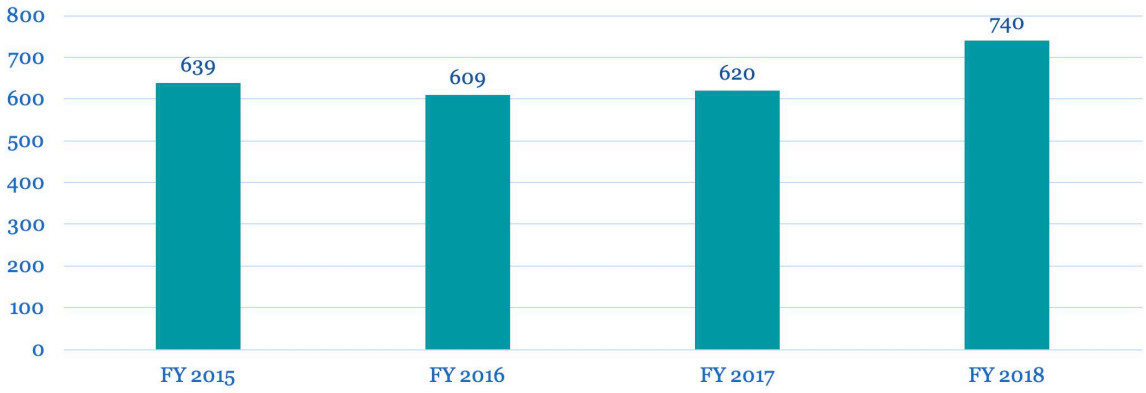
All contacts brought to the attention of Corporate Compliance are tracked through a web-based tracking tool. The Compliance Program utilized one vendor for 8-years to maintain consistency in tracking and monitoring. With the advancement of technology, it was prudent to assess the current marketplace. A Request for Proposal was posted, and six (6) vendors responded. A committee evaluated the respondents and chose a vendor based upon their commitment to provide hands-on management of the project and full implementation of the Compliance Issue Tracking Tool and leveraging a partnership with Salesforce, an existing CCH vendor currently utilized within Human Resources, to provide the software platform.

The overarching goal of the process is to assure consistency and to implement protections for our patients/members, the organization, our workforce, the government and the taxpaying public at large. The diagram that follows illustrates the approach to incident investigation and ensures that all the causes are uncovered and addressed by appropriate actions.

3. *Contact Volumes*

In FY18, 740 identified contacts were documented for the CCH Provider Compliance Program. The chart that follows illustrates the year-over-year activity which shows an increase of 120% compared to the previous fiscal year.

Year-Over-Year Volumes



4. *Contact Breakdown by Category*

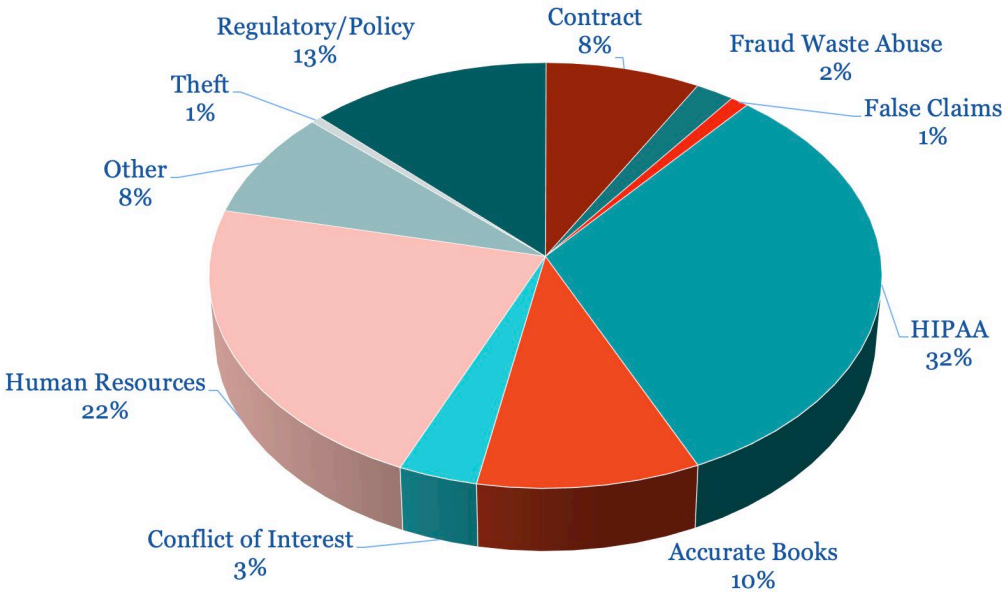
Categories have been defined that parallel the CCH Code of Ethics. The inclusion of a contact in a specific category does not substantiate the contact as a concern; rather it classifies the contact within a defined category.

The categories are classified as follows:

- Accurate Books and Records
- Conflict of Interest
- Contracts*
- False Claims
- Healthcare Fraud, Waste and Abuse
- HIPAA Privacy, Confidentiality and Security
- Human Resources
- Research
- Regulatory/Policy
- Theft
- Other

* Based upon the volume of activity surrounding contract review, separated this category from the previous category of Regulatory/Policy/Contract

5. *FY18 Contacts by Category*



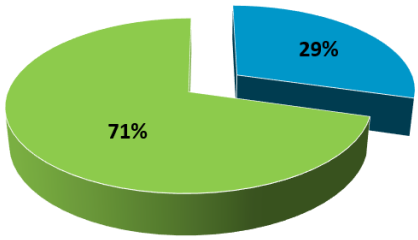
Categories			
HIPAA (Privacy/Security)	237	Conflict of Interest	26
Human Resources	163	Fraud Waste & Abuse	15
Regulatory/Policy	94	False Claims	7
Accurate Books	73	Theft	4
Contracts	60	Other	61

The majority of the contacts, 237 or 32%, were categorized within HIPAA Privacy. This percentage is consistent with previous years. Of the documented contacts categorized as HIPAA Privacy, approximately 15% or 37 contacts were confirmed privacy breaches that resulted in a total of 82 patient notifications.

The CCH Provider side of the Compliance Program provides support to the health plan for privacy issues. CountyCare experienced one (1) privacy breach that resulted in a total of five (5) member notifications. The one CountyCare breach in FY18 was caused by a Business Associate.

6. *FY18 Contact Status*
Of the 740 contacts were addressed throughout FY18, 96% or 709 contacts were resolved. Of the contacts resolved, More than 99% were either managed internally by Corporate Compliance or Corporate Compliance partnered with another area to address the concerns raised. Less than 1% were referred to other areas external to Corporate Compliance for management and follow-up. This metric is consistent year-over-year. The remaining 31 contacts were remained open at the end of the fiscal year and were carried over to FY19.

7. *FY18 Proactive vs. Reactive*
Of the 740 provider contacts managed during FY18, 29% or 218 contacts were proactive. The proactive category is defined as subjects, brought to the attention of Corporate Compliance by individuals seeking guidance prior to the occurrence of an event or activity. This percentage has decreased from 40% in FY17. The remaining 522 contacts or 71% were reactive. Reactive contacts are defined as contacts that occurred that were reported to Corporate Compliance after the occurrence.



Element 5

The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements.

E. Enforcing Standards

Broadened the scope of Standards enforcement through:

1. **Breach Assessments.** Reviewed investigations and provided remediation guidance to operational areas to minimize and/or eliminate breaches in the future and, utilized

the CCH Sanction Policy and Personnel Rules, to provide leadership guidance for disciplinary action.

2. **Breach Notification.** Investigated all instances of lost or stolen patient information, including paper and electronic. For all instances in which the data loss constitutes a breach as defined by the Breach Notification Rule, the breach notification requirements to the patient, the Secretary of HHS, and the media are completed. Corrective action plans are created and executed to improve the processes and counsel the physicians and employees involved.

3. **Conflict of Interest.** Provided guidance and developed Conflict Management Plans to preserve the integrity of the decision-making process.

4. **Investigations Resulting in Employee Related Corrective Actions.** HIPAA and Conflict of Interest complaints were investigated and resulted in providing leadership guidance to remediate the situations and avoid repetition of the incident.

5. **Partnerships with Governmental Agencies.** Corporate Compliance has engaged both state and federal agencies (e.g. the Department of Healthcare and Family Services (HFS) Office of the Inspector General, Medicaid Fraud Control Unit, Office for Civil Rights, Federal Bureau of Investigations, and the Secret Service) on a variety of matters. Additionally Compliance has worked with the Cook County Office of the Independent Inspector General.

Element 6

The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area.

F. Auditing and Monitoring

1. The Corporate Compliance Program conducted ongoing HIPAA auditing and monitoring during the relocations out of the Administrative building as follows:
    - Providing proactive record retention guidance throughout the move;
    - Monitoring garbage bins and vacated offices for PHI and working with operational leadership to educate staff when PHI was found;
    - Engaging Health Information Management when original medical record information was identified;
    - Communicating to the appropriate operational area(s) when other non-HIPAA contacts were identified related to the move (e.g. sharps and equipment found.)
2. The Corporate Compliance Program also served a resource to Internal Audit for outpatient coding expertise.

G. Risk Assessment

The Corporate Compliance Program risk assessment process is dynamic and adjustments are made throughout the year to respond to emerging issues with the resources available. This report highlighted activities that minimized risk through the introduction and enforcement of policies and standards, auditing and monitoring, education, and issue investigations with corrective action plans as appropriate.

Through surveys of executive leadership and key thought leaders within the organization, industry risks, and through the course of activities within prior fiscal years, the following areas were assessed in FY18:

- Securing Protected Health Information in paper and electronic and paper format through encryption and secure storage devices;
- Monitoring patient data to ensure accurate registration and deter identity theft and merged electronic health records;
- Directing Supply Chain Management during contract negotiations in the areas of compliance, privacy and security;
- Ensuring documentation supports the services performed through accurate code assignment;
- Defining contractual parameters of governmental Managed Care Plans excluding CountyCare;
- Assuring sanction screening was performed during the onboarding process for employees and vendors;
- Monitoring the 340B Drug Pricing Program through Pharmacy;
- Collaborating with Research to ensure regulatory requirements are followed;
- Guiding leadership in Record Retention and Storage requirements; and
- Working with physicians through the Illinois Drug Prescription Monitoring Program to eliminate fraudulent controlled substance prescriptions.

Element 7

The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

Sanction Screening Checks

- Continued to address regulatory requirements to avoid employing, engaging, contracting or agreeing with any individual or entity that is excluded or "sanctioned" from participation in a federal health care program or who is debarred from participation in federal procurement or non-procurement programs for the provision of goods or services.
- Determined, through an independent third party, no excluded or sanctioned CCH workforce members or vendors were identified throughout this fiscal year.

V. Looking Ahead

Overarching priorities have been established for CCH Corporate Compliance, to:

- Serve as a resource for our patients, our staff, and the public at large;
- Investigate all contacts/complaints brought to the attention of the Program;
- Promote the CCH Corporate Compliance Program internally and externally.

In addition, as noted earlier, through an annual risk assessment with executive leadership and key thought leaders, identification of emerging issues, and through the course of activities within prior fiscal years priorities have been identified. The Corporate Compliance Program will primarily focus on analysis and risk reduction related to fraud, waste, and abuse initiatives and continue to review, update and implement compliance policies and procedures.

FY19 priorities on the CCH provider side will focus on the following:

- Communication of importance of safeguarding hard copy Protected Health Information (PHI) to workforce members and their departments and provide guidance on record retention parameters and secure destruction processes as warranted;
- Development and compilation of a leaner, intuitive Records Retention Schedule for submission to the Local Records Commission. Once approved, append the current Records Retention policy and communication the update to the CCH workforce;
- Continuation of our partnership with IT Security to examine processes to safeguard electronic protected health information or ePHI as technological challenges arise (e.g. social media, texting, image sharing, etc.);
- Collaboration with Revenue Cycle operations to deter identity theft and merged electronic health records;
- Participation in continued oversight of the 340B Drug Pricing Program;
- Communication to accentuate the need for providers to manage their prescription activity with the Illinois Drug Prescription Monitoring Program to eliminate fraudulent controlled substance prescriptions;
- Oversight of auditing and monitoring code assignment based on medical record documentation and documentation guidelines; and
- Assessment of compliance with third party Managed Care contracts.